WARNINGER CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT INFORMATION *(BOTH SIDES)* DATE:_____

Name _____ Social Security No. _____

Home Phone _____Cell Phone _____ Work Phone _____

Address _____

Email_____Zip Code _____

Age _____ Birth Date _____ Sex M F Martial Status M S W D How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Insured's Name (If patient is dependent) _____ Social Security _____

Name of Insurance Company _____ Address _____

Name of Spouse _____ Occupation _____

Employer _____ Address _____

Patient's Nearest Relative _____ Address _____

Referred By (Who told you about us) _____

Is condition due to injury or sickness arising out of □ Your Employment □ Auto Accident □ Other Accident _____

Have you lost any days from work? Yes ___ No ___ How Many? _____ Date of last physical exam _____

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?: □ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Name _____ Date _____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?: □ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Have you had any auto or other accidents? □ No □Yes Describe: _____

_____

Date of last physical examination: _____ Do you smoke? □ No □Yes Drug Use □ No □ Yes

Do you drink alcohol? □ No □Yes how many per day? _____ How is your appetite? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

Are you pregnant? □ No □ Yes Date of last menstrual cycle _____

Have you ever had chiropractic care? □ No □ Yes

When? _____Why? _____

Where? _____

Were X-rays taken? □ No □ Yes

List any Allergies: □ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin

□ Ragweed/Pollen □ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye

□ Other: _____

List any Surgeries:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist

□Other:_____

Name _____ Date _____

List ALL Past Medical History conditions:

- ☐ Ankle Pain
- ☐ Arm Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Broken Bones
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Elbow Pain
- ☐ Epilepsy
- ☐ Eye/Vision Problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Foot Pain
- ☐ Genetic Spinal Condition
- ☐ Hand Pain
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ HIV
- ☐ Jaw Pain
- ☐ Joint Stiffness
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Menstrual Problems
- ☐ Mid-Back Pain
- ☐ Minor Heart Problem
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ Prostate Problems
- ☐ Shoulder Pain
- ☐ Significant Weight Change
- ☐ Spinal Cord Injury
- ☐ Sprain/Strain
- ☐ Stroke/Heart Attack
- ☐ Other:_____

List Type of Medications you are taking:

- ☐ Anxiety
- ☐ Muscle Relaxers
- ☐ Pain Killers
- ☐ Insulin
- ☐ Birth control
- ☐ Cardiovascular
- ☐ Allergy
- ☐ Seizure
- ☐ Other: _____

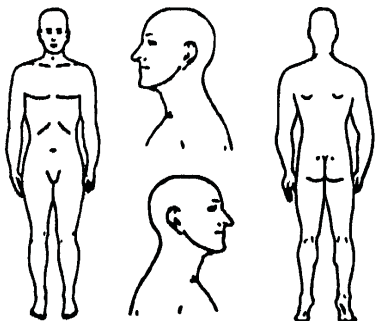
List your Family History: Please list all family members who had/has any of the problems below:
Example: High Blood Pressure - Grandmother

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Spinal Condition
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Multiple Sclerosis
- ☐ Neurological Problems
- ☐ Parkinson's
- ☐ Polio
- ☐ Prostate Problems
- ☐ Stroke/Heart Attack

Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

Please circle areas of pain



PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment_____

Are you insured? Yes_____No_____Company_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Warninger Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Warninger Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**